Physical Exam Form

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ School:_____ Grade: _____

To the Parent: Our school has a health program that is designed to improve, protect, and promote the health of each child. As part of our health program we encourage you to take your child to the doctor of your choice as soon as possible for a health examination and any necessary treatment. When the examination and treatment are completed and the doctor has signed this form, please return it to the *School District of Jefferson.*

Describe any physical, behavioral, developmental, or emotional problems the parent/guardian has concerning this child:_____

_____

Medical condition(s) of significance as observed by the health examiner:

_____

_____

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Laboratory

Height: _____ Weight: _____ Blood Pressure: _____

Hemoglobin/Hematocrit: _____ Urinalysis: _____

Vision: Both: 20/_____ Right: 20/_____ Left: 20/_____

Hearing: Right Ear: _____@1000 _____@2000 _____@4000

Left Ear: _____@1000 _____@2000 _____@4000

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Physical Assessment

	WNL	ABN		WNL	ABN
General Appearance			Teeth		
Skin			Lungs		
Eyes			**Heart**		
Ears			Abdomen		
Nose, mouth, throat			GU/GYN		
Lymph nodes			Musculoskeletal		
Thyroid			Gait/Posture		

Any restrictions in activity? _____Yes _____No If yes, please indicate restrictions below:

_____

Immunizations given: _____

Comments: _____

Name of Health Examiner: _____

Signature of Health Examiner: _____ **Date:** _____

Medical Facility Name and Address: _____